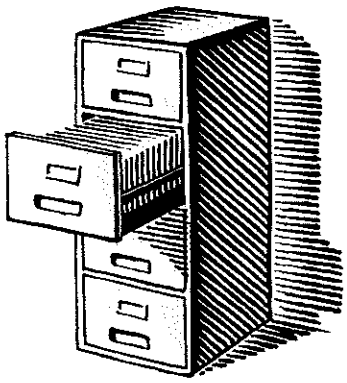
Safety Documentation



Accident Reporting and Recordkeeping

Accident Reporting and Recordkeeping Program
Kentucky Education and Workforce Development Cabinet
February 24, 2011

This written program has been developed assist management in complying with federal, state, and local safety standards and policies. It is not intended to supersede the requirements detailed in federal, state, and local safety standards and policies, but only as an aid in developing a facility's or agency's safety program. Management is responsible for reviewing the standards and policies for particular requirements which are applicable to specific situations and then tailor the safety program to fit the facility or agency.

Purpose of the Accident Reporting and Recordkeeping Program

Every work related or workplace injury occurring in a cabinet facility or program area, regardless of it severity, must be reported based on the matrix and specific instructions contained in this program.

Injured	Reported To	Documentation Used to Report
Employee	First Line Supervisor	IA1-First Report of Injury or Illness and Education Cabinet Investigation Accident Report
Customer or Visitor	Facility Manager	Education Cabinet Accident Investigation Report
Area Technology Center Student	Instructor	Education Cabinet Accident Report Form

IA1-First Report of Injury or Illness

1. Each employee is to notify his/her first line supervisor as soon as practicable after the work related injury or illness and it is the supervisor's responsibility to obtain all pertinent information and complete a Fire Report of Injury of Illness. The responsible supervisor shall complete the report online for entry directly to the Workers' Compensation Branch system; however, for supervisors who have limited internet access, the Workers' Compensation Branch may be contacted by phone. If an injury occurs after normal business hours (night or weekends), the report is to be completed the next working day.

2. The First Report of Injury or Illness must be submitted within three days of the injury or illness even if the employee does not plan to obtain medical treatment. The report must be complete and detailed with specifics. The signature page must be signed when the form is completed.

Workplace Amputations and Hospitalizations-KyOSHA

Incident-Fatality

Reporting Time-Within eight hours.

Report To-Ky OSHA Division of Compliance (502) 564-3070
Cabinet Safety Coordinator Office: (502) 564-7346, Cell: (502) 330-7463
After hours call OSHA (800) 321-6742

Time Limitation-Fatalities that occur more than 30 days following an incident are not required to be reported.

Incident-3 or More Employees Hospitalized in a Single Incident (Catastrophe)

Reporting Time-Within eight hours.

Report To-Ky OSHA Division of Compliance (502) 564-3070
Cabinet Safety Coordinator Office: (502) 564-7346, Cell: (502) 330-7463
After hours call OSHA (800) 321-6742

Time Limitation-Catastrophes that occur more than 30 days following an incident are not required to be reported.

Incident-Amputation

Reporting Time-Within 72 hours.

Report To-Ky OSHA Division of Compliance (502) 564-3070
Cabinet Safety Coordinator Office: (502) 564-7346, Cell: (502) 330-7463

Time Limitation-Not applicable.

Incident-1 or 2 Employees Hospitalized in a Single Incident

Reporting Time-Within 72 hours.

Report To-Ky OSHA Division of Compliance (502) 564-3070
Cabinet Safety Coordinator Office: (502) 564-7346, Cell: (502) 330-7463

Time Limitation-Hospitalizations that occur more than 72 hours following an incident are not required to be reported.

NOTE----Reporting time is the time from which an employer, employer's agent or another employee first becomes aware of the fatality, catastrophe, amputation or hospitalization.

Education and Workforce Development Cabinet Accident Investigation Report

1. When a First Report of Injury or illness is submitted due to an employee work related accident, the first line supervisor shall conduct an investigation and submit a completed Education and Workforce Development Cabinet Accident Investigation Report to management within 24 hours. A copy is to be forwarded to the Cabinet Safety Coordinator who will review it for any required follow-up.

2. All sections of the report are to be completed with special emphasis on corrective action or recommendations for corrective actions to prevent similar occurrences. The report can be obtained from the Cabinet Safety Coordinator.

Customer or Visitor Accident Report-Education and Workforce Development Cabinet Accident Investigation Report

1. When a customer or visitor is involved in a worksite accident, regardless of injuries or medical treatment, the facility manager shall conduct an investigation and submit a complete Education and Workforce Development Cabinet Accident Investigation Report to management and the Cabinet Safety Coordinator within 24 hours or the next working day.

2. The report will be reviewed by the Cabinet Safety Coordinator for follow-up actions. All sections of the report are to be completed with special emphasis on corrective action or recommendations for corrective actions to prevent similar occurrences.

Area Technology Center Student

1. All accidents, regardless of how minor, must be reported on the Education and Workforce Development Cabinet Accident Report Form. When an accident occurs, the report shall be completed within two school days of the occurrence. The instructor, injured student, witnesses, and ATC Principal shall complete the requested information on the form.

2. The original report shall be maintained in the ATC's files and copies shall be sent to the Cabinet Safety Coordinator and appropriate Area Supervisor.

Accident Recordkeeping

<u>OSHA Form 300 (Log of Work Related Injuries and Illnesses</u>

1. All Education and Workforce Development Cabinet worksites (regardless of size or location) shall maintain an OSHA 300 Log on a calendar year basis. The procedure is the same as used in the private sector (general industry and construction). Each worksite should have an assigned staff member responsible for maintaining the OSHA 300 Log. Below are the agencies in the Cabinet responsible for OSHA recordkeeping.

- Area technology Centers (each individual center)
- Center for School Safety
- Commission on the Deaf and Hard of Hearing
- Capitol Plaza Tower administrative offices
- Central offices in the Human Resources Building
- Education Professional Standards Board
- Environmental Education Council
- Facilities Management Branch
- KET
- Libraries and Archives (each Frankfort location)
- OET (each individual office)
- OFB (each individual office)
- OVR (each individual office)
- Central Offices in Frankfort

2. All employee work related injuries and illness must be entered in the OSHA 300 Log within six days after receiving knowledge that a case has occurred. If in doubt whether a case is recordable or not, log the case. An injury that may not be recordable at first may be recordable at a later time.

3. In the event of an OSHA inspection or investigation, the inspector will request to review the log for the previous year, and may request the current year log. Employers must provide records to an OSHA Compliance Officer in four hours. The OSHA 300 Log shall be maintained for five years following the end of the calendar year to which it relates.

OSHA Form 300A (Summary of Work related Injuries and Illness

Each Cabinet office and agency shall have an assigned staff member responsible for calculating and posting the OSHA 300A Summary. It is recommended that the staff person responsible for the OSHA 300 Log also be responsible for the OSHA 300A Summary.

All worksites shall post an OSHA 300A Summary from February 1 to April 30 for the previous calendar year. The summary is to be signed by the highest official at the worksite and shall be maintained in the files for five years following the end of the calendar year to which it relates.

The OSHA 300 Summary is to be based on the actual number of employees at the worksite and the recordable cases on the OSHA 300 Log.

Each Cabinet staff responsible for OSHA record keeping shall forward to the Cabinet Safety Coordinator in the Facilities Management Branch a copy of the completed and signed OSHA 300A Summary. This shall also be the point of contact of OSHA Recordkeeping in the Cabinet.

Attachments

Kentucky Education and Workforce Development Cabinet Accident Investigation Report: Used to report accidents involving state employees, customers, consumers, visitors, and vendors.

Kentucky Education and Workforce Development Cabinet Report: Used to report accidents involving Area Technology Center students.

Workers Compensation First Report of Injury of Illness: Used to report accidents involving state employees to the Personnel Cabinet for Workers Compensation purposes.

Occupational Sharps Injury Log: Completed in conjunction with the Accident Investigation Report to record sharps injury.

OSHA Form 300 Log of Work Related Injuries and Illness: Log of work related injury and illnesses for federal reporting.

OSHA Form 300A Summary of Work Related Injuries and Illnesses: Summary of work related injury and illnesses for federal reporting.

References

Commonwealth of Kentucky Safety and Health Manual, Section X

803 Kentucky Administrative Regulations 2:180

Ky OSHA Information Bulletin Reporting Workplace Amputations and Hospitalizations

Kentucky Revised Statutes Chapter 342

29 Code of Federal Regulations 1904

Kentucky Education and Workplace Development Cabinet
Accident Investigation Report

Employee: _____ Job Title: _____
Cabinet: _____ Department: _____
Division / Facility / Location: _____
Length of Employment: ☐ Less than 1 mo. ☐ 1-6 mos. ☐ 6 mos.-5 yrs ☐ Over 5 yrs.
Time in Current Job: ☐ Less than 1 mo. ☐ 1-6 mos. ☐ 6 mos.-5 yrs ☐ Over 5 yrs.

Section II: Accident Description

Include Date/Time of occurrence, describe what happened, Task being performed, Object(s) involved.
PLEASE BE SPECIFIC:

Section III: Injury Information

☐ Abrasion ☐ Contusion ☐ Laceration ☐ Puncture ☐ Heat ☐ Avulsion
☐ Burn ☐ Dermatitis ☐ Foreign Body ☐ Fracture ☐ Cold ☐ Radiation
☐ Inhalation ☐ Absorption ☐ Ingestion ☐ Injection ☐ Sprain ☐ Strain
☐ Loss of Consciousness ☐ Cumulative Trauma Disorder ☐ Other: _____

Section IV: Severity

☐ None ☐ Fatality ☐ Lost Time __Number of Days Lost ☐ Restricted Activity/Duty
☐ Job Transfer __Number of Days of Job Transfer

Section V: Body Parts

☐ Head ☐ Face ☐ Neck ☐ Shoulder ☐ Toe ☐ Eye ☐ Back
☐ Leg ☐ Knee ☐ Ankle ☐ Foot ☐ Chest ☐ Ear ☐ Arm
☐ Hand ☐ Finger ☐ Other: Describe: _____

Section VI: Treatment / Action Taken

☐ None ☐ First Aid Only ☐ Personal Physician ☐ Emergency Room ☐ Admission
☐ Medical Monitoring Only ☐ Other: *(Describe)* _____

Section VII: Causal Factors

☐ Combative Person ☐ Improper Guarding ☐ Inadequate Lighting ☐ Hazardous Storage
☐ Defective Equipment ☐ Inadequate Ventilation ☐ Contact w/ Irritants ☐ Hazardous Weather
☐ Distraction by Others ☐ Inadequate Warning ☐ Unsafe Surface ☐ Faulty Safety Equip.
☐ Faulty / Poor Design ☐ PPE Not Used ☐ Contact w/ Toxin ☐ Unsecured Equip.
☐ Hazardous Procedures ☐ Insect/Animal Attack ☐ Poor Housekeeping ☐ Unsafe Procedures
☐ Unauthorized Use ☐ Wrong Tool Used ☐ Inhaled Toxin ☐ Unsafe Speed
☐ Insufficient Training ☐ Improper Apparel ☐ Unsafe Position ☐ Unsafe Posture
☐ Defeated Safety Equip. ☐ Failure to Observe Rules / Regulations
☐ Investigation Reveals Accident was Beyond Employee Control ☐ Other: _____

Section VIII: Action(s) Taken to Prevent Recurrence

_____ _____ _____
Supervisor Title: Date

Distribution: Safety Coordinator Richard T. Owen, 601 East Main Street, Frankfort, Kentucky 40601 Files: Office Files
E-mail: Richard.Owen@ky.gov

EDU-F08

EDUCATION CABINET
ACCIDENT REPORT FORM

Student, Employee, or Other _____ Date/Time of Occurrence _____
Name _____ Facility _____
Address _____ Region _____
Age ____ Dept/Class _____ High School (if applicable) _____
Social Security Number _____ Days lost from school/work -0- _____

DESCRIPTION OF INJURY

APPARENT NATURE OF INJURY

☐ Abrasion ☐ Concussion ☐ Puncture
☐ Amputation ☐ Cut ☐ Scald
☐ Asphyxiation ☐ Dislocation ☐ Scratch
☐ Bite ☐ Fracture ☐ Shock
☐ Bruise ☐ Laceration ☐ Sprain
☐ Burn ☐ Poisoning ☐ Other

Explain Other:

PART OF BODY INJURED

☐ Abdomen ☐ Elbow ☐ Head
☐ Ankle ☐ Eye ☐ Knee
☐ Arm ☐ Face ☐ Leg
☐ Back ☐ Finger ☐ Mouth
☐ Chest ☐ Foot ☐ Other
☐ Ear ☐ Hand

Explain Other:

Describe the nature of the injury (cut, third finger, left hand, etc.)

Describe medical attention received, by whom, and address:

DESCRIPTION OF ACCIDENT

Did accident occur while in an instructional activity? ☐ Yes ☐ No If no, explain

Specify any machine, equipment, or tools involved _____

Were proper machine guards being used? ☐ Yes ☐ No
Was individual given safety orientation? ☐ Yes ☐ No
Was individual doing assigned work? ☐ Yes ☐ No
Was individual using Safety Equipment? ☐ Yes ☐ No
Was high school notified (if applicable)? ☐ Yes ☐ No
Was this accident due to faulty equipment? ☐ Yes ☒ No

Describe Safety Equipment

If Safety Equipment was not in use, explain:

Action taken to prevent recurrence:

Was supervisor present at accident? ☐ Yes ☐ No If no, explain

Did individual have permission to use equipment? ☐ Yes ☐ No If no, explain

Education Cabinet
Revised 01/07

FOR SAFETY SECTION USE ONLY
Degree of Injury: Minor Severe

DESCRIPTION OF ACCIDENT (continued)

Injured's description of accident (specify in detail)

Individual's Signature _____ Date _____

Was family notified by the facility? _____

****

Witness's description of accident (specify in detail)

Witness's Signature _____ Date _____

****

Supervisor's description of accident (specify in detail)

Supervisor's Signature _____ Date _____

****

Administrator's Comments

Administrator's Signature _____ Date _____

****

List all non-student / supervisor witnesses and address:

1. 2. 3.

Date copy of accident report form forward to Central Office (if applicable) _____

Kentucky Tech Personnel: Sign and date original report and forward to the Safety Coordinator, 20th Floor, Capital Plaza Tower, Frankfort, KY 40601

Other/Cabinet Personnel: Sign and date original report and forward to the Safety Section at:

601 East Main Street
Frankfort, Kentucky 40601

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address Incl. zip)

Carrier/Administrator Claim Number: N/A | Report Purpose Code: N/A

Jurisdiction: N/A | Jurisdiction Claim Number: N/A

Insured Report Number: N/A

Employer's Location Address (If different) | Location No.: N/A | Phone No.

Sic Code: N/A | Employer FEIN: N/A

Carrier/Claims Admin

Carrier (Name, Address & Phone Number): N/A

Policy Period: N/A To | X Check if self insured

Claims Admin (Name, Address & Phone Number): N/A

Carrier FEIN: N/A | Policy Number or Self-Insured Number: N/A | Administrator FEIN: N/A

Agent Name & Code Number: N/A

Employee/Wage

Legal Name (Last, First, Middle) | Date of Birth | Social Security Number | Date Hired | State of Hire

Address (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone | No. of Dependents

NCCI Class Code: N/A

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK | # Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM | Date of Injury or Illness | Time Occurred ☐ AM ☐ PM | Last Work Date | Date Employer Notified | Date Disability Began

Employer Contact Name/Phone Number

Type of Illness/Injury | Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No

Type of Illness/Injury Code: N/A | Part of Body Affected Code: N/A

Department or location where accident or illness exposure occurred

All Equipment, Materials, or Chemicals Employee was using when accident or illness exposure occurred.

Specific Activity the Employee was engaged in when the accident or illness exposure occurred.

Work Process the Employee Was Engaged in when accident or illness exposure occurred.

How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill.

Cause of Injury Code: N/A

Date Returned to Work | If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment

0 ☐ No Medical Treatment
1 ☐ Minor: By Employer
2 ☐ Minor Clinic/Hosp
3 ☐ Emergency Care
4 ☐ Hospitalized > 24 hr.
5 ☐ Future Major Medical/Lost Time Anticipated

Other

Witness to Accident (Name & Phone Number)

Date Administrator Notified | Date Prepared | Preparer's Name & Title | Preparer's Phone Number

IA-1 (2/95)

SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE

Kentucky Education and Workforce Development Cabinet

Occupational Sharps Injury Log Instructions

Reference-OSHA Standards at 29 CFR 1904.8

1. Supervisors are to complete the Occupational Sharps Injury Log in conjunction with the Education Cabinet Accident Report Form.

2. Supervisors must investigate and report on the Occupational Sharps Injury Log all work related needlestick and sharps injuries that involve, or potentially involve, another person's blood or potentially infectious material. Contaminated sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

3. OSHA Standards require management to record on the OSHA 300 Log all work related needlestick and sharps injuries involving objects contaminated with another person's blood or other potentially infectious material. However, the Standards prohibit management from entering the name of the affected employee on the log to protect the employee's privacy.

4. When completing the OSHA 300 Log entry for the injury, management simply enters "privacy concern case" in the space reserved for the employee's name. Management is required to maintain separate, confidential file of privacy concern cases. Each privacy concern case shall consist of the Education Cabinet Accident Report Form and Occupation Sharps Injury Log completed for the incident. The Cabinet Safety Section shall also maintain a confidential file of all privacy concern cases for the cabinet.

Kentucky Education and Workforce Development Cabinet
Occupational Sharps Injury Log

Supervisors are to complete this form in conjunction with the Education Cabinet Accident Report Form.

Name of Employee_____ Employee Work Unit_____

Assigned OSHA Log ID #_____ Employee Work Location_____

Date of Injury_____ Time of Injury_____ Completed by_____ Date_____
(Employee health/ER staff)

Location of Injury (Check all that apply)	Sharp Involved	Did the sharp being used have engineered injury protection(s)?
☐ Finger ☐ Hand ☐ L ☐ R ☐ Arm ☐ L ☐ R ☐ Face or Head ☐ Torso ☐ Leg ☐ L ☐ R ☐ Other: _____	Type: _____ Brand: _____ Model: _____ **Body Fluid Involved** _____ _____ _____	☐ Yes ☐ No ☐ Don't Know **Was the protective mechanism activated?** ☐ Yes ☐ No ☐ Don't Know **When did the injury occur?** ☐ Before activation ☐ Don't Know ☐ During activation ☐ After activation

Job Classification	Location and Department	Procedure
☐ Doctor ☐ Nurse ☐ Intern/Resident ☐ Patient Care Support Staff ☐ Technologist: ☐ OR ☐ RT ☐ RAD ☐ Phlebotomist/Lab Tech ☐ Housekeeper/Laundry Worker ☐ Trainee, specify: _____ _____ ☐ Other: _____	☐ Patient Room ☐ ICU ☐ Outside Patient Room ☐ Emergency Department ☐ Operating Room/PACU ☐ Clinical Laboratory ☐ Outpatient Clinic/Office ☐ Utility Area ☐ Other: _____ _____ _____	☐ Draw venous blood ☐ Draw arterial blood ☐ Injection ☐ Start IV/Central line ☐ Heparin/Saline flush ☐ Obtain body fluid/tissue sample ☐ Cutting ☐ Suturing ☐ Other: _____ _____ _____

Describe, in detail, how the exposure incident occurred (e.g., the procedure being performed, the device being used, the body part affected, objects or substances involved and how they were involved). Include medical treatment received by employee.

_____
_____
_____
_____
_____
_____
_____
_____
_____

This form but is based on sharps injury documentation requirements found in OSHA's revised Bloodborne Pathogens Standard. These requirements are in addition to OSHA's employee injury and incident reporting requirements.

Original January 4, 2010

OSHA's Form 300

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year _____

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name _____

City _____ State _____

Identify the Person | Describe the Case | Classify the Case

(A) Case No.	(B) Employee's Name	(C) Job Title (e.g., Welder)	(D) Date of injury or onset of illness (mo./day)	(E) Where the event occurred (e.g. Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from acetylene torch)	Using these categories, check ONLY the most serious result for each case:				Enter the number of days the injured or ill worker was:		Check the "injury" column or choose one type of illness:				
						Death (G)	Days away from work (H)	Job transfer or restriction (I)	Other recordable cases (J)	On job transfer or restriction (days) (K)	Away from work (days) (L)	(M) Injury (1)	Skin Disorder (2)	Respiratory Condition (3)	Poisoning (4)	All other illnesses (5)
					Page totals	0	0	0	0	0	0	0	0	0	0	0

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

Injury (1) | Skin Disorder (2) | Respiratory Condition (3) | Poisoning (4) | All other illnesses (5)

OSHA's Form 300A (Rev. 01/2004)

Summary of Work-Related Injuries and Illnesses

Year 20__ __

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and Illness Types

Total number of... (M)			
(1) Injuries	_____	(4) Poisonings	_____
		(5) Hearing loss	_____
(2) Skin disorders	_____	(6) All other illnesses	_____
(3) Respiratory conditions	_____		

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Establishment information

Your establishment name _____

Street _____

City _____ State _____ ZIP _____

Industry description (e.g., *Manufacture of motor truck trailers*)

_____

Standard Industrial Classification (SIC), if known (e.g., *3715*)

____ ____ ____ ____

OR

North American Industrial Classification (NAICS), if known (e.g., 336212)

____ ____ ____ ____ ____ ____

Employment information *(If you don't have these figures, see the Worksheet on the back of this page to estimate.)*

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

_____ _____
Company executive Title

( ) - _____ / /
Phone Date